The Calman Report: does training matter to trainees?

Mark Evans and Christine Johnson

One hundred and fourteen psychiatric trainees in the South Western region were canvassed by questionnaire concerning their knowledge of and attitudes towards the recommendations of Calman Report, (DOH, 1993). Of the 78% of senior registrars and 80% of registrars who replied, the majority knew of the major recommendations mainly from reading articles and talking to colleagues. The 50% response rate from the senior house officers perhaps reflected a lack of knowledge and an erroneous perception that the report was of less relevance to them. The article reports responses to both structured questions concerning the facts, and comments received on more controversial aspects.

Specialist training has become an increasing focus of attention in response to the various demands of reducing juniors' hours of work, reassessing the hospital medical staffing structure and increasing the amount of consultant-patient contact. Scotland (1990) offered two possible models: first, a small, elite body of consultant/managers with a small group of trainees (where the majority of clinical work is undertaken by non-consultant career grades), or second, a large body of consultants with increased clinical involvement. It does not seem, however, that an overall strategy has been considered, rather that individual policies such as the New Deal, and *Achieving a Balance* (DHSS, 1986) are implemented piecemeal, to jostle for position: "manpower planning has never been integrated into other NHS plans" (Hunter & McLaren, 1993). This occurs in a setting of financial constraint and central controls of junior medical staff numbers.

The Calman Report (DOH, 1993) was prepared in response to the European Community's view that Britain was infringing directives on specialist training recognition. The report proposes a shorter, more clearly defined training period and the introduction of a combined higher training grade to replace registrar and senior registrars, with an increase in consultant numbers. A Certificate of Completion of Specialist Training would be awarded, which should enhance mobility of specialists. The government accepted the recommendations in December 1993.

Specialist training in psychiatry has already undergone significant changes, and as Caldicott (1993) has stated, "The main implications relate to a clear definition of specialist training". Does this begin as a senior house officer (SHO)? Where does the Membership examination fit in? What happens to sub-specialty training? As Kisely (1993) has said, "Psychiatric trainees need to ensure that their views on the future of training are heard".

This article is in response to that challenge and describes the results of a questionnaire sent out to trainees in psychiatry to assess their knowledge of and opinions about the Calman Report.

The survey

A questionnaire with stamped addressed envelope was mailed to 114 psychiatric trainees in the South Western region and a reminder was sent one month later. The questionnaire was in two parts. Part one assessed sources of knowledge and asked eight factual questions about the report. Themes examined included the effects that changes would have on length, structure and competition in psychiatric training; the ratio of training compared to service commitment; the numbers of part-time/job share and consultant posts; the range of consultant career choice and mobility; and the agreed rate of implementation of proposals.

In part two, comments were invited on six questions or controversial statements taken from the report. Themes included which grade should form the combined higher training grade; whether training standards would be compromised; proposed replacement terms for trainees; the 'gap' (period between completion of specialty training and consultant appointment); sub-consultant grades and sub-specialty training.

Findings

Replies were received from 36 out of 46 senior registrars, 16 out of 20 registrars and 24 out of 48 SHOs. The majority of SRs (52%) and registrars (60%) had read about the report in journals

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Table 1. Part I: Knowledge of content of Calman Report

Correct answers to questions asked	No (%) of trainees responding correctly					
	SR (n=36)		Registrar (n=16)		SHO (n=24)	
Length of specialist training will decrease	30	(83%)	15	(94%)	11	(46%)
Number of consultant posts will increase	30	(83%)	13	(81%)	14	(58%)
Structure of specialist training will increase	26	(72%)	9	(56%)	10	(42%)
Training compared to service commitment will increase	24	(67%)	11	(69%)	12	(50%)
Competition on entering specialist training will increase	22	(61%)	10	(62.5%)	10	(42%)
Changes to be implemented within three years	11	(30.5%)	6	(37.5%)	4	(16.7%)
Consultant career choice and mobility will increase	10	(28%)	7	(44%)	9	(37.5%)
Number of part-time and job share posts will stay the same	1	(3%)	1	(6%)	0	(0%)

while very few had read the report itself. Of the SHOs, none had read the report and 45% had heard little or nothing about it.

Table 1 shows the numbers and percentages of correct responses (according to the report) to part one of the questionnaire for each training grade. Trainees knew least about the proposed effects the report would have on the numbers of part-time/job-share posts, the range of consultant career choice and mobility and the time span for the report's implementation. They knew most about the proposed effects on consultant numbers, the length of specialist training and the ratio of training compared to service commitment.

Part two of the questionnaire was less consistently filled in. On average a third of the registrars and senior registrars and over half of the SHOs failed to comment on each statement. Most comments were received on the proposed combined training grade, replacement for the term trainee and the 'gap' period.

Both senior registrars (83%) and registrars (72%) felt that the SHO grade should not be included within the recommended specialist grade because it would force an early career choice and loss of flexibility. However, SHOs were equally divided 'for' and 'against'; those 'for' cited job stability and improved training.

On the question of whether standards would be compromised by a shortened training, registrars and SHOs both felt this would not happen if quality and monitoring were improved. However, senior registrars suspected compromise, and emphasised the importance of experience and maturity as qualities which take time to develop.

All grades were equally split about a change in terminology for trainees, those disagreeing with the change felt that new names would be unnecessary or ambiguous. The term 'assistant psychiatrist' for a doctor in specialist training was universally unpopular.

Much concern was expressed about the 'gap' period, particularly from senior registrars (80%) and registrars. There were worries that consultant expansion would be insufficient, and those in the 'gap' may become a source of cheap labour, and that 'the bottleneck' would shift to this level. Other concerns related to who would employ those in the 'gap' period, and what would happen at the end of it. Implications for research were not addressed in the report.

Senior registrars (69%) agreed that a new NHS sub-consultant grade should not be introduced, fearing a two-tier system with poor terms and conditions of employment. However, the majority of registrars and SHOs who commented were in favour of the grades, seeing the benefits of a specialist grade with fewer management responsibilities for those with family commitments. There was a universally negative response to the report's lack of consideration of sub-specialty training, as it was felt that this was particularly relevant to psychiatry.

Comments

The level of knowledge about the Calman Report was broadly similar between registrars and senior registrars. The fact that SHOs knew less and commented less may reflect the high numbers of those considering a career in general practice and those not yet committed to a career in psychiatry. This may also explain the lower response rates among SHOs and it was postulated that those who did not respond had less knowledge than those replying. Only two respondents knew that the report proposed no changes in the numbers of part-time and job-share posts. This seems surprising in view of the increasing popularity of these posts within psychiatry.

The majority of trainees knew that consultant numbers should increase with the proposals, while a minority knew that consultant career choice and mobility should increase. It may be that this reflects preferential reporting of certain information in medical journals or that positive

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outcomes were not believed or not focused upon.

The comments collected in the survey reflected the level of training, with registrars' and senior registrars' opinions tending to overlap. Most of the SHOs who commented felt that their grade should be included within the recommended specialist training grade, in contrast to Caldicott's (1993) suggestion that specialist training should start at senior registrar level. Comments from the other grades reflected concern that enough time be given for basic training and 'testing the water' so that a more informed career choice could then be made.

The College view on training programmes in psychiatry is that they are already 'organised', although the bottleneck between registrar and senior registrar grades lengthens training inappropriately (Caldicott, 1993). The discrepancy we found between the views of lower and higher grade trainees on whether shortening training would compromise standards may be reflecting which side of the 'bottleneck' the trainee is on. Senior registrars, having made the most difficult transition in their careers, saw this shortening negatively as a loss of time to develop experience and maturity while more junior trainees may resent the extra time spent in training forced by the 'bottleneck'. Of the many concerns expressed about the 'gap' the most relevant may be the view that NHS trusts will start to employ post CCST (Certificate of Completion of Specialist Training) doctors who are not consultants as a form of cheap labour so that a sub-consultant grade is introduced through the back door.

One interpretation of our results is that in the more junior levels, potential changes are taken more at 'face value' and their impact assessed on that basis. Senior registrars, by contrast, appear to place changes in the context of wider issues and are perhaps more circumspect as a result. For instance, comments tended to be qualified by statements such as 'if the funding is available'. Such circumspection may be realistic in the light of the announcement by the Health Minister (Dr Brian Mawhinney) that there will be no extra funding for implementing the recommendations, and that the government would be easing restrictions on numbers of SHOs and staff grade doctors (Dawe, 1994).

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